

justifiable in cases of irreducible luxation to expose under the antiseptic spray the seat of the injury, and, if necessary, to excise the injured joint. The patient was a workman, aged 52 years, who came under the care of Dr. Volkmann, with an irreducible perineal luxation of the head of the right femur, of two months' duration. No attempt had previously been made to replace the head of the bone. Dr. Volkmann tried on several occasions manipulation to reduce the luxation, but without success; although the head of the femur could be moved from the perineum to the back of the ilium. The perineal luxation having been converted into an iliac luxation, the lower limb was then extended by weights, and kept at rest for six weeks. At the end of this period, as there was still much deformity, and the limb remained quite useless, it was decided to expose the joint with the view of removing any obstacle to reduction, or, this failing, of performing resection of the displaced portion of bone. The head and neck of the right femur were well exposed by a long incision made, as in resection, over the great trochanter. No obstacle to reduction could be discovered. The tendons of the muscles passing to the great trochanter were then divided, but without any good result. The head of the femur remained fixed in its abnormal position, and could not, in spite of frequent attempts, be returned to its cavity. No proper capsule was observed, but the soft part immediately around the joint had become callous and indurated. After further dissection the head of the femur was so far isolated that it could, through adduction of the limb, be forced out from the wound. There was then found stretched over the acetabulum, and closely adherent to the margins of the cavity, a thick mass of muscle, the more superficial layers of which had undergone fibrous induration. As it was thus found useless to make any further attempt to replace the head of the femur in the acetabulum, Dr. Volkmann removed this portion of bone, together with the great trochanter. The operation was performed under the antiseptic spray, and the wound, after the removal of the displaced head of the femur, carefully washed out with carbolic acid solution, drained, and subsequently dressed with Lister's gauze. After the patient had been removed to his bed, the right lower limb was extended by a weight of ten pounds. The man made a rapid recovery, the wound healing by first intention, and with the absence both of local reaction and of surgical fever. After long-continued extension by weights, there was found to be but little difference in the length of the right as compared with that of the left lower limb. Nine months after the operation, the patient was able to make very good use of the limb in locomotion. The direction of the foot was normal, and the movements, active as well as passive, of the lower limb at the hip could be performed with considerable freedom.—*London Med. Record*, Aug. 15, 1877.

Acute Tuberculosis of Synovial Membrane.

M. LAVERAN, of the Val de Grâce Hospital, records (*Le Progrès Méd.*, Oct. 25th) the following instructive case: A young soldier, twenty-two years of age, who had served only eight months, was admitted into the hospital on June 21st, 1876. He was well nourished, but had never been robust, and had in infancy suffered from an attack of right-sided pleurisy. Six days before his admission he began to suffer from painful swelling of the ankles and knees, the latter being tender and the seat of much effusion, especially the right. There was but slight pyrexia, and no cardiac complication. The case was regarded as one of subacute rheumatism, but on the next day the temperature rose to 102.2°; the patient began to suffer from cough; there was some dulness at both pulmonary bases, pleuritic friction at left base, and sibilant and mucous râles over the whole chest. From this date onwards the pulmonary signs became more marked, with increas-

ing dyspnœa, cyanosis, and a temperature ranging from 102° to 105° . Death took place on July 4th, fifteen days after admission, and twenty-three days after the first onset of arthritis pain. The post-mortem examination revealed acute miliary tuberculosis, the pleura, lungs, peritoneum, liver, spleen, and kidneys presenting gray granulations in abundance. Four larger tubercular masses, composed of aggregated granulations, occurred in the pons and medulla, but did not appear to implicate any nerve-roots. There was no meningeal tubercle. Both knee-joints were examined; in each there was an excess of transparent synovia, most in the right, and the injected synovial membrane, with its fringes, was in each joint studded with slightly elevated grayish granulations, the size of a pin's head. Under the microscope the tubercles were found to arise in the deeper layers of the synovial membrane, and to present a central granular opacity, with a marginal zone of nucleated cells. Giant cells, of round form, granular contents, and oval nuclei along their margins, occurred in the centre of every granulation. These articular granulations precisely resembled in structure the miliary tubercles infiltrating the lungs and other organs. M. Laveran draws attention to the occurrence of arthritis as the first symptom of a general tuberculosis, and that of so predominant a character as to lead to a mistake in diagnosis, which was rectified as the pulmonary signs became more marked. He believes that the articular pains frequently complained of by the subjects of acute tuberculosis, are probably indicative of the implication of the synovial membranes in the disease; and, further, that some fatal cases of "acute articular rheumatism," accompanied by pleuritis, meningitis, etc., may really be of tubercular nature. The apparently older date of the masses in the pons and medulla in this case was, he believed, simply due to the nodules being formed by the coalescence of a large number of granulations similar to those found elsewhere in the body, and that the outbreak was, in fact, nearly simultaneous in all parts. The instance of a chronic pleurisy with adhesions on the right side was the only evidence of antecedent disease in this case.—*Lancet*, July 28, 1877.

On Infra-patellar Hygroma.

According to Prof. TRENDLENBURG, of Rostock (Von Langenbeck's *Archiv für klinische Chirurgie*, Bd. xxi., Heft. 1), dropsical distension of the deeply-seated infra-patellar bursa cannot be regarded as a very rare affection. Two cases of this form of hygroma are reported, and a description is given of its symptoms. The infra-patellar bursa, the contours of which are too small, under healthy conditions, to be distinctly seen or felt, forms, when distended by fluid, a well-marked tumour. The distension of the bursal sac takes place chiefly in the upward and lateral directions, an abnormal protrusion being thus formed on each side of the ligamentum patellæ. The change thus produced in the external form of the knee may escape notice if the corresponding bursa in the other limb be similarly affected. The lateral swellings are best marked when the leg is semi-flexed. In this position of the limb each of the lateral depressions that are observed under normal conditions is replaced by a prominent fluctuating tumour. In cases of hygroma of this deeply-seated bursa, flexion of the leg cannot be caused to its full extent. In hydrops genu, on the other hand, flexion at the knee is not interfered with, even when there is considerable intra-articular effusion. There is usually some tenderness in the region of the swollen bursa, and some pain and a feeling of stiffness in front of the knee after active movements of the leg. The author made out in each of his cases a tender spot at the inner side, and just above the level of the tubercle of the tibia. Pain often comes on spontaneously in the affected region, and the patient complains at times of a sensation of tension below the patella and of weakness of the joint. There is slight lameness, and the affected limb